Patient Consent for Services

Patient Name:	DOB:

Consent to Treatment. I consent to and authorize the providers and staff at Grow Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work. Grow Pediatrics is a teaching clinic and I may receive care from other providers or staff who are in training and who are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

Assignment of Benefits/Payment for Services. I authorize payment of any and all benefits to Grow Pediatrics. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Grow Pediatrics to get payment for my care. If I am eligible for payment from more than one type of coverage, Grow Pediatrics will return any extra payments to the payor. If I have an unpaid bill at Grow Pediatrics, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Grow Pediatrics.

Release of Information. I consent to and authorize Grow Pediatrics to use and disclose my protected health information for treatment, payment, healthcare operation purposes including, but not limited to, care coordination and quality assessment and improvement activities. Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations including clinically integrated networks and/or accountable care organizations in which Grow Pediatrics participates, and/or other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to Grow Pediatrics and/or a clinically integrated network or accountable care organization in which Grow Pediatrics participates.

Patient Rights and Privacy Practices. You and your family's rights and our privacy practices are posted in main areas within Grow Pediatrics. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Grow Pediatrics' Privacy Officer.

Other Individuals Authorized to Consent to Treatment. In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

My signature here means I have read the information on both sides of this form and understand it. This consent is valid until revoked.

_____	_____	_____
Print Name	Signature	Date